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AUTHOR Prinsen, Bert
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ABSTRACT

This document comprises three papers related to the implementation of early childhood education, health care, and support programs. The first paper is a brief reflection on the nature of implementation, based on the contributions of Boudewijn Bekkers. The second is a proceedings chapter by Marian Hanrahan titled "Community Based Innovative Practices in Child Health Care: Early Childhood Care and Development Support Programs." The third paper is also a proceedings chapter, by Bert Prinsen titled "Issues of Program Design and Implementation." Together, these three papers consider implementation as a second stage in the process of innovation as applied to community-based support programs that promote education and health care for disadvantaged young children. Hanrahan's chapter addresses the implementation of a variety of programs to establish and strengthen international communication about community-based early childhood development programs focusing on disadvantaged populations such as migrants, drug users, and refugees and covering political issues, costs, and quality. Prinsen's chapter discusses nurturing community-based programs through improving programs that combine family support and health promotion; stimulating participation of target groups, marketing strategies focused on policy makers, health care workers, and the public; and evaluating cost-effective programs. (Contains 40 references.) (JPB)

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Issues of implementation of early childhood education and support programs

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Bert Prinsen

Based on contributions of Marian Hanrahan and Bert Prinsen (chapter 1 and 12) in "Community health, community care and community support", proceedings of the invitational conference on innovative childhood care and development support programs (Netherlands Institute of Care and Welfare / MIM Cooperative, Utrecht, the Netherlands, 1997).

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Issues of implementation of early childhood education and support programs

Thank you mister chairman.

What I am propose to do in the next ten minutes in reflecting upon the contribution of Boudewijn Bekkers is to tell you something about:
- the concept of implementation
- some characteristics or conditions of implementation
- a recommendation for a policy of implementation and
- at last I have a statement about the controversial issue of the link between large scale implementation and the benefits for the disadvantaged people.

My contribution will be in the perspective of my experiences in the field of child health care, health promotion and community based support programs. So whenever this does not fit to everybodies concepts than you may realize that my opinions will be coloured in this way.

The concept of implementation

First of all, talking about implementation means that you are looking at the second stage of the process of innovation. There has to be something - a programme, a project, an intervention or what so else - to implement. This has been developped in the first stage of innovation, being the probably most likely answer to a question or problem. The Dutch ZON Programme for Prevention has noticed this as the three stages of innovation. They are called development, implementation and continuity (Sheet 1).
In my opinion the stage of continuity is essential for the success of implementation. Therefore I would like to incorporate this stage as an integral part of the implementation stage. When we are looking more closer to this process (sheet 2) then we will find in the concept of implementation and continuity two specific items which were underestimated in the concept of large scale implentation presented by mr. Bekkers. Succesfull implementation based on:
- the empowerment of people and communities
- building on the strengths of individuals and communities
- the development of confidence and greater control over their own lives,

needs a far more greater linking to the disadvantaged people as yet has been realized.
Like Microsoft's Bill Gates said in the Harvard Business Review of October 1997 about the shift his company made on their strategy of innovation: "From the beginning of your innovation you need the communication with your consumer groups, not only in the implementation stage". We can learn much from this observation. At that stage you are too late getting the people involved. Innovation and especially implementation means communication and marketing at early stages.

The second specific item on the concept of implementation I like to mention is the power of fruitful continuity. We need to give more attention to the stages of sustaining the innovated behaviour of professionals and volunteers and the internalization of the new development in the financing system, legislation and policy system at all levels.

The implementation of community based support programs

The strength of community based support programs - like the Community Mothers programme in Dublin, Barker's Early Childhood Development Programme and the Dutch MIM Program lies in the combination to tackle health and socio-economic determinants, coupled with activities to empower women to take charge of their lives. Positioned side by side with the reduction of socio-economic health differences is training and educating parents. Health, care and welfare are meeting each other in a fruitful coalition.
When we compare the programs, we are struck by a number of common characteristics. We mention five common characteristics in their program design: a holistic approach, home based, social support and networking, sharing experimental day to day and specific professional knowledge and the full participation of parents.
The holistic approach in these programs has not only to do with the professional environment from

which they are initiated, but also touches upon the programs' contents. Socio-scientific and health-scientific thought meet in these programs.
In the day-to-day reality of the parents participating in the program, this provides a fruitful synthesis. We must understand that in the parents' perception questions on education, care, health, growing, the child's development are side by side. These parents do not make the same distinctions which empirical-analytical thought of science advocates. Rather, they link these separated worlds and ask for support "so that they can solve their own problems in their own way".

Community based support programs which integrate a contextual approach with multiple goals and multiple targets, empowerment, shared goals, proper timing and cost-effectiveness have to go a long way to change both the parents, the child as well as the professionals and the politicians. The primary challenge is to continue to explore ways in which partnerships can be developed between statutory and non-statutory agencies, without contributing to a sense of competition. There is a strong need for international co-operation for advancement on development, research and implementation but also on the fronts of policy, leglislation, financing and societal support.
The dissemination of these type of programs is influenced by the attitude of policy makers. They want an effective program at affordable costs. Implementing this kind of program requires top down as well as bottom up strategies:
- to enhance the quality of care and the development of quality assurance variables for the programs themselves;
- to execute evaluative research which is needed to be able to develop effective programs;
- to involve policy makers, practitioners and the public at large.

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'Cues for action' needed for innovations

Implementing a new developed program needs at the individual level 'a cue for action'. In the case of community based support programs the 'cues for action' for professionals can be situated in:
- empowerment: professionals discover and gain trust in people's own powers and abilities;
- professional impotence: the repeated experience of not being able to reach people, in particular in underprivileged circumstances, with prescribing behaviour as opposed to the introduction to the results of an activating attitude and behaviour;
- the communication gap: the inability on the part of professionals to transfer knowledge, information and skills to the public (the mothers);
- solidarity: the manifest need to provide support and care to the weakest members of society;
- program effects: the pedagogical, health and socio-economic effects of 'community based support programs';
- vision on man and science: lifting the separation of the sciences; breaching the gap between the medico-scientific and the socio-scientific thinking and the effects of this separation for mothers and children.

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A policy of implementation

"*Think global, act local*" is an often heard expression in circles of the World Health Organization and other international health organisations (Evers et.al., 1990). It expresses very well the two simultaneous and interacting, yet very different strategies which are necessary in order to improve people's health and quality of life on a wider scale.

Let us examine the different levels at which improvements in dissemination of information and the quality of life can be implemented: the decisive link of the parents' world and the world of professionals.

1 The participating community needs a focal point. The empowering attitude and the pro-activating behaviour of nurses, doctors, parents and volunteers are according to Barker and others decisive for a chance of success. In the local community the program is being given a human face, resulting in the parents feeling that the program is theirs.

2 On a community level we find the specified applications of the programs each with their specific program conditions and management. The organisation is locally embedded in the

community and within this representatives of the target groups are given a voice. Local nurses or social workers take care of the continuous assessment of the program to ensure quality of care. On this level continuous adjustment is necessary all the time. Re-inventing the wheel is not necessary, for it is quite possible conceptually to transfer, implement and disseminate community based support programs but utilisation and adaptation according to local needs and circumstances will always be necessary.

3 On the national level program-concepts can be compared, ideology and paradigms can be analyzed, and implementation strategies utilised. The national program strategy can help to ensure continuity of funding and legislation.

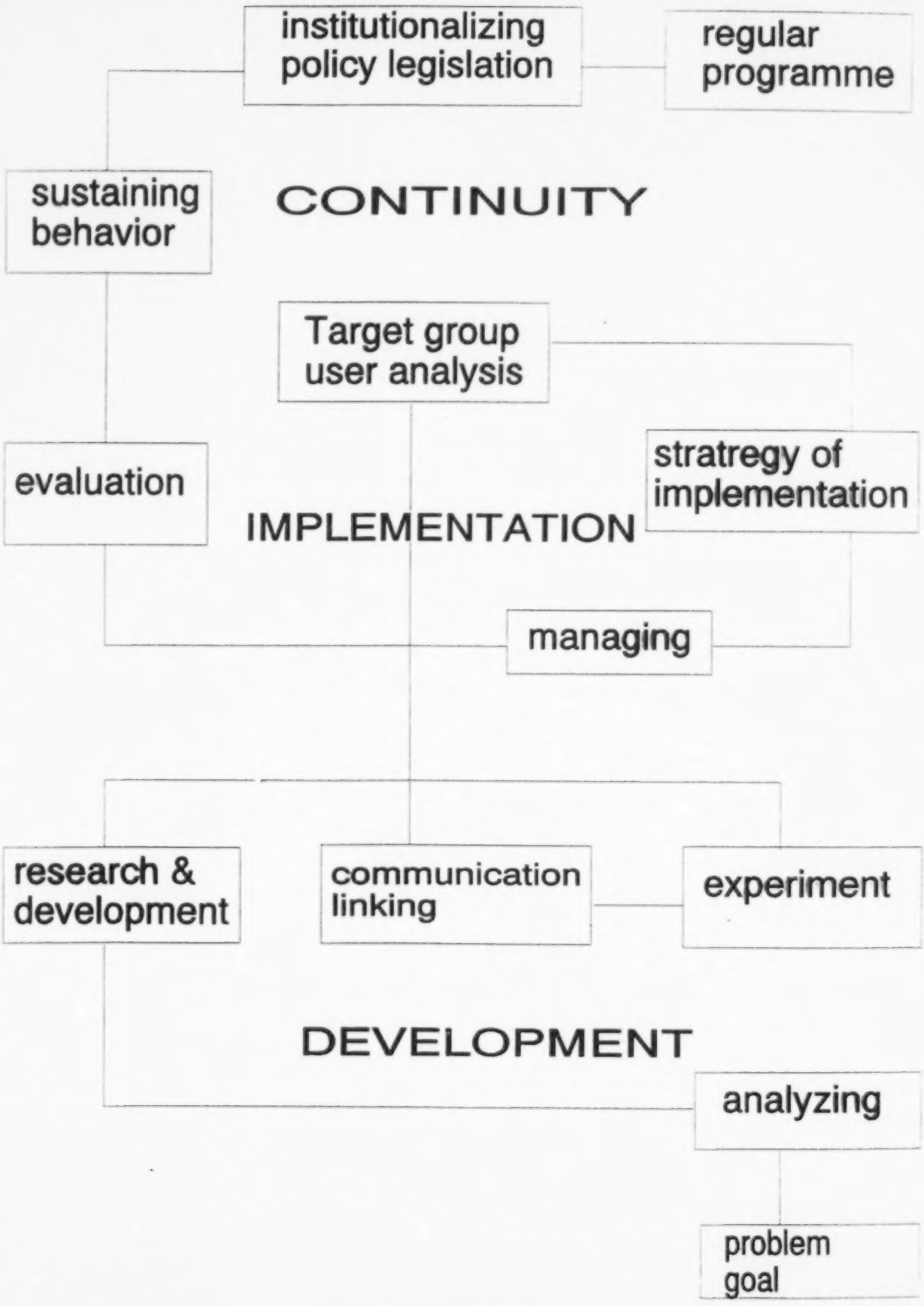
I would like to propose the concept of "global policy and local acting" - which means global power on policy, financing and program strategy at the top and specific power on program acting (including the local strategy, local funding) at the basic level of the people - the users - all evaluated on outcome measures.

In my opinion the implementation of community based support programs is likely to be succesfull because special attention has been given to:

- quality improvement of program development in strengthening the synthesis of family support programs and health promotion;
- stimulating participation of the target groups;
- marketing strategies which are well constructed and adequately managed and focused on policy makers, health care workers and the general public;
- evaluating research of cost effective programs;
- the development of a concept of global policy and local acting.

Statement on implementation

Implementation is one of the three, the middle stage of the process of innovation. You are starting with the development of an innovation, you are ending with the stage of sustaining the innovation by institutionalize it. So reaching this point, the success of large scale implementation of a program for a great number of people is always the beginning of failure of small scale innovation for more than some disadvantaged parents and children. The sustaining values of success, wealthy and healthy life never correspond to the values of failure, poverty and chronically illness. So whenever you enjoy the large scale implementation of a program you have to be suspicious about your success while loosing the goals for other disadvantaged people and you have to turn around and innovate your own mind in developing the next program for other social excluded groups. In some way that's the tragic part of the story of innovation and large scale implementation.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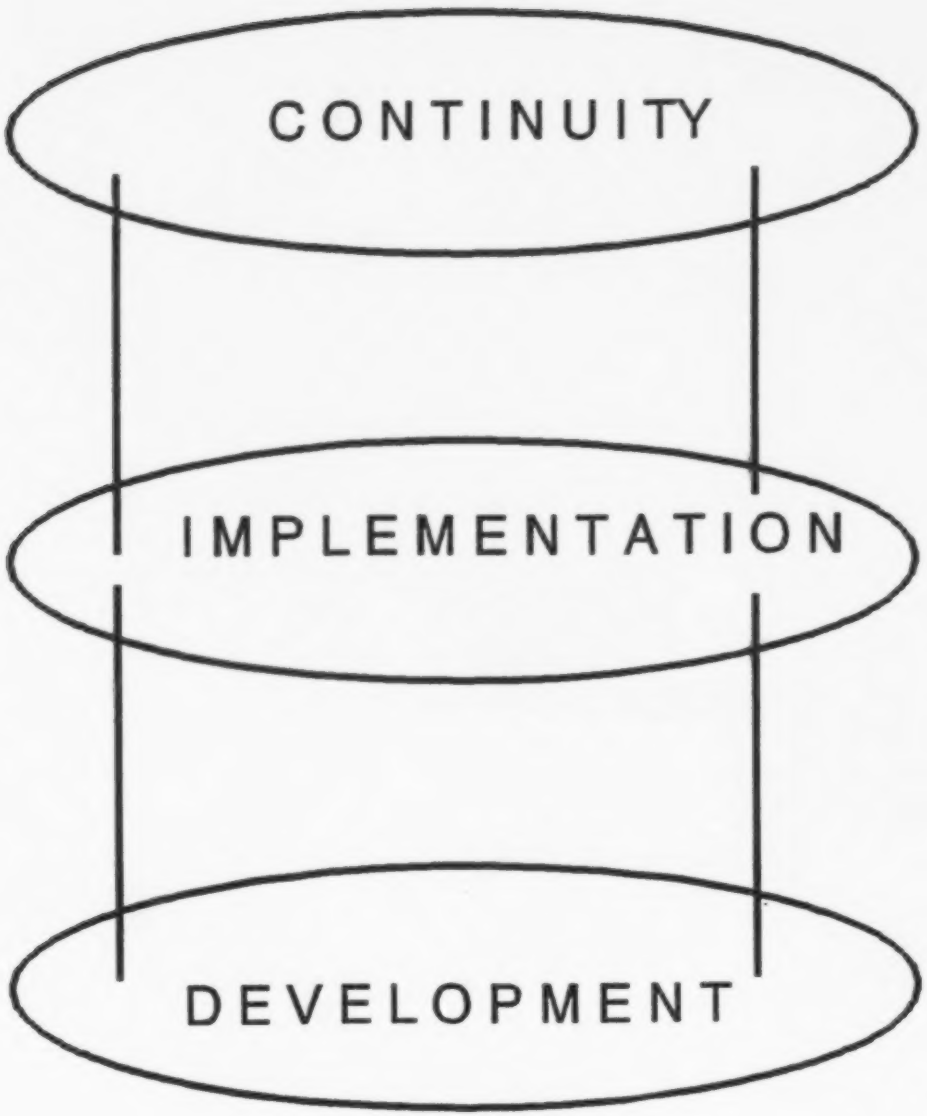

2. Community based innovative practices in child health care: Early Childhood Care and Development support programs.

(Chapter 1, see note 1)

Marian Hanrahan

Introduction

Growing awareness of the importance of and demand for early childhood programming has created a need for knowledge and processes that can inform planning and program choices in what is a rapidly advancing field. Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services. To meet those needs and to enhance the well-being of young mothers and their babies an international conference was organised with an opportunity to:

- exchange experiences, methods and effective strategies with community based early childhood developmental programs;
- discuss the generalisation and implementation of effective, preventive strategies and methods of health promotional activities for parents with babies aged 0 to 18 months;
- start an international network with the view to strengthening international exchange of program information.

The conference gave opportunities to help finding the answer to the following questions:

1 What are the effects found as a result of ECCD-programming?
2 Which conditions need to be met to reach optimal results?
3 Which strategies are helpful and effective changing the current statutory services systems in such a way that they enhance the needs of children living in deprived circumstances?

Children in need

One and a half billion children will be born in the decade of the 1990s **note 2**. The great majority will be born in what are commonly referred to as "developing countries". Increasingly, due to economic conditions, children in these countries will be born into poverty and situations which threaten their chances for optimal human growth and development. However, poor living conditions do occur in developed countries also (Townsend & Davidson 1980). Migrant workers and refugees often live in poor housing conditions and the growing number of people living rough are a new fact of life. World-wide, the quality of the environment in which millions of children are growing up is inadequate by any number of criteria. Overcrowding, lack of potable water and sewage facilities, lack of adequate food, and inadequate caretaking characterise the environments of many young children.

In most of the countries represented by the participants of the conference we do not have the large scale problems that exits such as starvation, lack of access to health care and the lack of support services for protection of young children. Nor do we have large scale refugee camps close to war zones. But, as illustrated by Myers, in the developed countries there are still determinants present which can prevent healthy children from reaching their full potential. "Many of the same conditions of poverty and stress that previously put children at risk to die now put them at risk of impaired physical, mental, social and emotional development in their earliest months and years. Delayed or debilitated development in the early years can affect all of later life. It can also be prevented. And, because children are amazingly resilient, it can be overcome. But overcoming early difficulties is not only inefficient, it requires greater commitment than most people in privileged positions have been willing to give, up to now. As a result, millions of children will be deprived of their right to healthy and normal development. They will fail to live up to their potential and will be further thwarted in their attempt to escape from the persistent cycle of poverty. Many of the survivors will lead lethargic, unproductive, unrewarding, and dependent lives" (Myers 1992;1995).

Frequent infection (most commonly diarrhoea) and malnutrition account for over 50% of infant deaths in developing countries. But, malnutrition and diarrhoea do also occur in developed countries, if only for different reasons. British nutritionists warned recently health conscious parents and vegan parents against the use of low fat yoghurts, other low fat milk products and 'light' drinks. These

parents should make sure that their children receive sufficient carbohydrates, fat and proteins, as growing toddlers with low fat, low carbohydrates and low protein intake were showing signs of malnutrition. And the admission of infants and young children in hospitals during summer months is increased, due to overheating of the baby, lack of fluids, contaminated food and drink (diarrhoea and dehydration).

In terms of physical, intellectual, emotional and social well-being, the period from conception to age six is the key to subsequent growth, development and ultimate productivity. From prenatal through the sixth year there are distinct stages. The stages include: intra-uterine, intrapartum (birth itself), post partum (birth to 1 month), early infancy (first six months), late infancy (6 - 12 months) and toddler stage (1 - 3 years). Some children start life with a disadvantage, as they may have suffered a birth trauma, are born too early or too late or have weight too low according to their gestation. Or they may indeed suffer from a congenital defect. Children have different needs, depending on where they are within these stages. In order to create a program for young children, it is critical to have more specific information on their needs. A delineation of developmental differences is provided for the first two age groups (Donohue-Colletta 1992):

Infant's need	**Toddler's need**
stage protection from physical danger	same needs as in the infant stage, plus:
adequate nutrition	support in acquiring new a chance to develop some motor,
adequate health	language and thinking skills
adults with whom to from attachments	a chance to develop some independence
adults who can understand and respond to their signals	opportunities to begin to learn to care for themselves
things to look at, touch, hear, smell, and taste	help in learning how to control their own behaviour
opportunities to explore the world	daily opportunities to play with a variety of objects
appropriate language stimulation	

Children living in socially deprived circumstances
Health inequalities have been found in all countries where research on socio-economic health differences (SEHD) has been carried out (Laughlin & Black 1995). Children from deprived backgrounds score poorly on many health indicators. The prenatal and infant mortality in children from low socio-economic groups is several times higher of those from the high socio-economic background. Differences are also noted in birth weight and size. Social inequality is often seen as an important environmental determinant of children's health and well being (World Health Organisation 1993). Studies on accessibility of health care and behaviourial risk factors are frequently the object of interventions. Physical and environmental factors, like maternal deprivation or living conditions, appear to have rarely been the object of interventions. Health educational approaches offer a promising perspective to reduce SEHD but mass communication, like written educational materials, does not seem to work in low socio-economic groups. Showing a video tape, or work face-to-face and step-by-step with others, seem to have an effect to redress risk factors or adequate use of services (Gepkens & Gunning-Schepers 1994). The ecology of the family (specific situation and location) has a greater influence on development and upbringing than is generally assumed (Winter at al 1995). In deprived areas in the Netherlands, a Dutch version of the Home Instruction Program for Pre-school Youngsters (HIPPY) is widely available to deal with pre-schoolers as young as 1.5 years of age up to age four.

In our programs we often aim to target the program to the disadvantaged sections of our communities. Usually they are socio-economically disadvantaged. Examples are the mother who uses hard drugs, teenage and travelling mothers, migrants (including refugees). These travelling mothers could be divided in the traditional Romany, Cinti, new age, or like in Ireland, the indigenous travellers. The use of our type of programs is one of the possibilities of contributing change and could work positively on women's health.

Position of mothers using hard drugs
There are very few ECCD programs geared towards mothers using hard drugs. If mothers are using the statutory services they have difficulty adhering to the appointed times. Therefore, specialised and usually small surgeries exist to deal with the specialised care that these mothers and babies need. They are often organised by voluntary agencies or sometimes by a municipal health authority. In some countries mothers who 'do drugs' are in danger of losing their child, due to the professionals' fear that the situation is too dangerous and they fear for the child's safety.

Position of travellers, Romany and Cinti
Special attention is given to travellers, migrants and refugees. These groups are difficult to reach. Family members have strong ties, rituals and customs. Mortality and morbidity figures of very young children show higher incidence and prevalence of infectious disease, accidents and poor health status due to nutritional disturbances due to iron (hypochromic anaemia) and vitamin D (rachitis) deficiency (Buszman et al 1995). From a study in Britain the Travelling Gypsies are generally well informed about interpretations of health and illness events. But the experiences of the travelling communities suggest that the cultural values of both the health care system and the health care professionals marginalises the specific needs of this particular group by failing to adapt. For instance, the mobility of lifestyle is incompatible with a service specifically designed for a settled population with a permanent address (Moreton 1995). Similar signals are present in other countries.

Position of migrants
International migration is complex **note 3**. With the influx of several million migrant workers and their families from both European and non-European countries, and growing numbers of asylum seekers and irregular migrant since the early 1980s, international migration has become an issue of major concern for Europe's policy makers and the public at large. Europe has become a de facto region of large-scale immigration (Paiva 1995). In many EU-countries there are migrants working and taken in as refugees from other European nations. Some migrants suffer from ailments that are not present in the indigenous population. In the past 15 years research has shown differences in health and disease between migrants' children and Dutch children. Apart from major socio-economic differences other factors are responsible for the health equalities found. For example: Mortality figures of Moroccan and Turkish children are 2.5-3 times higher than those of Dutch children. The main causes are perinatal problems, congenital malformations, accidents and drownings, infectious diseases of the respiratory tract and SIDS. Illnesses are also different in the area of infectious diseases, lactose-digestion and inherited diseases like thalassasaemia and sickle-cell anaemia (Schulpen 1995).

Position of refugees
Refugee parents need safety and security, a friend, a neighbour, a non professional or a professional to facilitate their transition, from past to present and from one culture to another. They need information about reactions to stress and information about how to cope. The experiences of refugee children and their families are characterised by long term efforts to cope with combined and interactive effect of traumatic events and cumulative stressors and to adjust to the stressful changes that are taken place at various levels. This developments mean that the basic ECCD Program need to address multicultural issues, psychological and health problems. Refugee families have often lost their support system. Helping families to create a new support system network and utilise the resources within the family can be seen as an important step in the process of help. The informal support reduces the impact of stressors and facilitates coping with negative life events (Bala 1995).

ECCD-type programs
Most of the programs that we discussed dealt with infants. Some are dealing with toddlers aged 1.5 - 3 years. We will be talking about programs that deliver health and social support to vulnerable parents and very young children. Parents care about their children and want the best for them. They already know a great deal about child rearing. This knowledge is respected. Further information and support can help them to create an environment that will ensure positive child development. Our programs do not focus on parents with older children like Home Start or HIPPY. They work mainly with young inexperienced parents. They are adapted, and share the same common roots. Because they are comprehensive and integrated programs there is an opportunity created to produce important health and social gains at the level of the child, the parents and the community (Meyers

1991). It extends its influence on the professional expertise, care delivery and the educational requirements of nurses. These programs aim to empower parents. Empowered parents may be able to influence their span of control so that their world becomes more manageable. A wide variety of inputs is required to support children's growth and development. An important thing is that all the inputs require someone to interact with the child. Very young children are not capable of obtaining what they need on their own. The role of adults in supporting children's learning is to provide them with opportunities to work with concrete objects, to make choices, explore things and ideas, experiment and discover. Children also need opportunities to interact with peers and adults in a safe environment that provides the child with security and acceptance.

Health and early child development **Note 4**
From the moment of conception important developments occur that affect the brain, the physical body, and the chemistry of a child. These all have an impact on that child's ability to learn, to thrive, to grow and be healthy. The first 6 years of a child's life form the foundation for all later development. Developmental psychologists have demonstrated that in the early years a child develops all the basic brain and physiological structures upon which later growth and learning are dependent. Emotionally and socially, as well, the child develops many of the abilities upon which later social functioning is based. Attention to young children from the beginning can help to prevent later difficulties. Good nutrition, nurturing, mental stimulation and interactions for infants are the best preventive measure for avoiding developmental delays and disturbances. Physical, mental, social and emotional development and learning are inter-related. Progress in one area affects progress in the others. Therefore, we pay attention simultaneously to physical development (through health and nutrition), mental development (through education and stimulation), social-emotional development (providing affection, and opportunities for social participation), and spiritual development; a holistic and integral approach.

Given the importance of the environment in promoting children's learning, it is also possible to focus interventions on changing the child's environment. For example, increasing family income, upgrading health and enhancing the social and political milieu will affect children's growth and development. It is important that children have the opportunity to construct their own knowledge through exploration, interaction with materials and imitation of role models. This means that adults should use methods that fit with the child's growth pattern, not only in the cognitive area, but also in the affective, perceptual and motor areas. Activities should provide the child with a developmental appropriate challenge. Development and learning occur as children interact with people and things in the environment. We stimulate activities which help parents to encourage, nurture, stimulate, talk to and play with their children. Children learn and develop better if they are actively involved. They learn in part through constructing their own knowledge. Children live within a context - family, community, culture - and their needs are most effectively addressed in relation to that context. Our programs are often linked with the well-baby clinics and statutory services. Sometimes they are even part of those statutory services and specially targeted at children in need. Support to the family and community can help children. Support to children can help the family and community. Support of early development yields rich benefits not only in immediate ways but also over time. All young children deserve to be cared for, nurtured and supported in their development.

Political issues
Working with families in deprived areas is based on a set of principles which are similar to those in the Health for All strategy of the World Health Organisation and the Primary Health Care philosophy (WHO 1978;1985):

- *the empowerment of people and communities*
- *building on the strengths of individuals and communities*
- *the development of confidence and greater control over their own lives.*

These principles are the basis of the programs in Ireland, the Netherlands and United Kingdom. They are all programs in which mother themselves play the pivotal role. Experienced mothers, supporting, facilitating areas stimulating other inexperienced mothers with some coaching by professionals. Visiting mothers are usually influenced by experimental learning practices through their experiences in life (WHO 1993; Torkington, & Landers 1995). They have learned and build on their own

experiences and developed their own self-confidence. They have thus empowered themselves. It seems reasonable to expect that the availability of our programs could facilitate maternal employment and productivity, especially away from home. Research results in Ireland, the UK and the Netherlands show indications that visiting mothers are progressing to paid employment or that they go back to school to continue with their education. Increasingly, mothers who received the program themselves wish to participate as a visiting mother when they reach the end of their involvement in the program. Or they start a support / self help group looking after each other's children, which enable them to go back to part-time work outside their home. This would add to family income and thereby contribute to improve their child's life. The mothers indicate that their earnings increase the percentage of total family resources devoted to their children's needs.

Cost

Costs is an important issue. And, relatively speaking, most countries do not spend much money on preventative programs. Activities that have shown their worth are screening and inoculation programs in well baby-clinics. New innovative developmental and care programs still need to show their worth. And that is difficult to achieve, especially when the effects need to be shown in a relatively short time span. There are major determinants of costs. These are: age at start, frequency, duration, ratio, staff qualifications, supervision and administration, and parents' involvement and community context. These program characteristics have the most influence on costs and are relatively easy to mandate or regulate. Most often cost analysis is concerned with average or marginal cost per child rather than total cost of a program. Average cost per child (unit cost per child) is the total cost divided by the number of children served. Marginal cost per child is the addition to cost required to serve another child. When national efforts in preventative programs remain relatively modest, marginal costs could be substantially below average cost because there are significant fixed costs that can be spread over a larger number of children. In any event a focus on average or marginal costs requires the measurement of an important variable, the number of children served. At present information along these lines have not yet been presented in some of the existing programs. Our programs need to show their effects on health and welfare determinants. Additionally, they have to prove that they enhance existing statutory programs. In this way the cost-effectiveness of statutory childhood care and development programs are enhanced.

Vested (medical) interests are at stake. One way of dealing with this problem is providing comparable data between costs in existing programs and those of the innovative programs. The economic feasibility of alternative programs could then be assessed by the analysts and administrators. Unfortunately, there are as yet no cost-effectiveness studies or cost benefit studies done on existing program components dealing with development and care. By reason of this the funding of ECCD programs is often additional, and on a subsidy-basis.

Valuing quality in early childhood services and research

Early childhood development programming is now viewed by research and professional bodies as the first and essential stage in the basic education process. There is a growing appreciation of the crucial importance of the child's earliest years, and the need to support and facilitate families and communities in their role of providing an environment supportive of the child's overall development. Facilitation is about believing from the beginning in people's ability to learn and grow, not just about learning techniques. Countries that succeed in mobilising government, local authorities, communities and voluntary organisations in the care and education of very young children have been able to make an important contribution towards population information and the education of women. Very often these activities also encourage changes in behaviour and promote healthy lifestyles.

ECCD programs are evaluated internationally (Olds et all 1986; Olds & Kitzman 1990; Dunst & Trivette 1988). They have been shown to be effective in countries when the starting point of the health and welfare of children was very low (Larson 1980). In Western Europe there are some immediate health gains to be got with the sort of programs we are providing (Johnson et all 1993; Barker & Anderson1988; Barker 1992). There are favourable outcomes around safety and the prevention of accidents. In Ireland and the UK gains have been recorded with the reduction of children taken into care and the reduced number of children suffering abuse. In the Netherlands these findings cannot be shown because the law prohibits a link with regional or national registrations or social security numbers. The national systematic reporting of child abuse cannot be used, as a

national professional guideline for nurses and well-baby clinic teams has not been nationally implemented. Analysis of some determinants of health and welfare are however possible: nutrition, self esteem of the mother, the perceived health status of the mother and her social network and use of child care facilities. Multi centre research of programs which basically come from the same roots could be possible. This would be an exiting prospect using the conceptual framework combining an 'ecological' approach with the concept of 'developmental niche' (Woodhead 1996; Bronfenbrenner, 1979; Super & Harkness 1986). Children are depicted as growing up in the context of the micro-systems of family and of pre-school (or nursery). Within each micro-system, the impact of the environment is powerfully mediated by the beliefs and expectations of care givers, as expressed through the extent and character of their specific interactions with children. The relationship between the micro-systems, in terms of shared or conflicting mutual beliefs of care givers, as well as active points of contact, constitute the meso-system. Finally, although children's immediate experiences are directly shaped within the micro- and meso-systems, indirectly they are strongly influenced by wider forces, such as the employment patterns of parents (the exo-system) and by the overall economic and political situation (the macro-system).

In conclusion
Our programs will go some way to help the children in need. The strength of our programs lies in the combination to tackle health and socio-economic determinants, coupled with activities to empower women to take charge of their lives. This conference may give some indications on the development of appropriate programs for children under the age of three. Children within this age group are relatively invisible. Yet, as research indicates, it is a very critical period in terms of health, nutrition and cognitive stimulation. The participants of this conference could help to bridge the gap in developing effective programs for infants, toddlers and their families. Hopefully we contribute to a decrease of socio-economic health differences and increase the score on major health indicators. We have to prove that these programs do contribute to give children an opportunity to develop to their highest potential.

Positioned side by side with the reduction of socio-economic health differences is training and educating adults. This is the other major focus of our programs. The programs are developed with the aid of experienced mothers themselves. The experienced mothers use experimental learning techniques to share their experiences and exchange information with the inexperienced mother. Both are actively involved and share the responsibility for their own learning. Many mothers have high levels of creativity, imagination and understanding of children's needs. The work experience as a mother is often not recognised. These experienced mothers are professionals in their own right. They have learned from life. They contribute towards quality assurance because their experiences and reports pinpoints inadequacies of existing services. Their experiences however, do not lead towards a formal recognition (certificate or partaking in policy decisions), and rarely do they get an opportunity to prepare others for the role as a visiting mother (Torkington & Landers 1995).

The dissemination of information about ECCD-programming is influenced by the attitude of policy makers. They want an effective program at affordable costs. A discussion is ongoing whether to pay experienced mothers, or to keep the program community based and working strictly with volunteers. The opponents of the strictly volunteer rule say that the activities undertaken are considered work, for which women are trained and then asked to participate for a minimal set of hours. These women exchange their time, skills and knowledge as a mother for a fee. If they are paid the activity can be counted as a first step to full employment and financial independence from state support.

Health, care and welfare are meeting each other in a fruitful coalition. But program development is not finished. International co-operation could lead to new opportunities to solve some of the problems which are encountered. Cost effectiveness is an essential ingredient of a good ECCD-program. Our ECCD-programs have multiple targets (child, mother/parents and the community). They are individually geared home visiting programs. But it must be said, cost-effectiveness is a relative concept. An inexpensive program, in absolute costs, can actually be costly if it does not produce results in the eyes of policy makers. Human development is a continuous process. But the decision as to when to measure an effect is a difficult question. Usually it is short term effects that are measured, but this then brings up the issue of sustainability. The appropriate evaluation instruments to measure progress in children of that tender age not always available.

ECCD-programs which integrate a contextual approach with multiple goals and multiple targets, empowerment, shared goals, proper timing and cost-effectiveness can go a long way to change both the mother and the child. The primary challenge is to continue to explore ways in which partnerships can be developed between statutory and non-statutory agencies, without contributing to a sense of competition. There is a strong need for international co-operation for advancement on all fronts.

Notes

1 The focus of this book is serving children in need through the provision of innovative effective early childhood care and development (ECCD) programs. I have included an appendix which will give you some working definitions of used terms.

2 Consultative Group on Early Childhood Care and Development, *Meeting Basic Learning Needs*. UNICEF, 1990.

3 A degree of classification is useful for the purpose of discussion and analysis. For this purpose the classification used by the International Organisation for Migration is included in appendix 1. They were taken from: Appleyard, R., *International Migration: Challenge For The Nineties*, Geneva, IOM, 1991 p. 22.

4 These texts are based on articles which are stored at the WWW-side on Internet; Presented by the Consultative Group on Early Childhood Care and Development.

5 The body of this text was taken from http/www.ecdgroup.com/eccd.html, presented by The Consultative Group on Early Childhood Care and Development. The authors used the following references in their text:
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- International Early Childhood Care and Development: Where we stand and the Challenges we Face, Judith L. Evans, Secretariat, Consultative Group on Early Childhood Care and Development. Paper presented at the National Consultation on ECCD organised by the National Inter-agency Committee on Early Childhood Care and Development. November 11-12, 1994, Quezon City, Philippines.
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3. Issues of program design and implementation (chapter 12)

Bert Prinsen

In this book we are able to benefit from the experiences and results of programs from five different countries. We have looked at these programs from various perspectives. It gives us confidence to work towards further development and implementation of community based support programs. Let us all hope that they have a sound and healthy future.
Implementing this kind of program requires different strategies:
- to enhance the quality of care and the development of quality assurance variables for the programs themselves;
- to execute evaluative research which is needed to be able to develop effective programs;
- to continue the selling of these kinds of programs to policy makers, practitioners and the public at large.

These are some of the main issues of development and implementation for the next few years, bringing the results of program development to a widespread innovation in the field of youth development and early child care. One question comes to our mind: "What are the present perspectives of developing and implementing such programs in countries in the Western world?" To find possible answers to this question is the main thrust of our contribution.

Development and implementation

The development of practicable (inter)national programs in the field of health care and pedagogical support of parents of young children is a long-term matter. Ever since the first innovation theories were formulated (Havelock, 1971; Rogers and Shoemaker, 1971) we have known that the development and dissemination of such new programs takes place according to predictable patterns and a well-known set of procedures. On the other side the actual course of innovation can be very freakish and unpredictable in nature. This is determined by social and political circumstances. The experiences with community based support programs in various stages of development and use in the five countries described in this book confirm this pattern. The framework, theory and the design of the program have been sufficiently developed and it appears to be an intrinsically and systematically useful and feasible program. Application variations and use are increasing, but as yet the programs have not been widely disseminated. Program implementation is difficult. This is due mainly to the fact that in community based support programs two different worlds collide. Worlds with different attitudes, values and norms: health care and welfare work. In addition we are also dealing with a combination of two types of programs: family support and health promotion. There is ample cause for closer inspection of the main issues that determine the development and implementation chances of these programs. We will discuss respectively:
- the different roles of the mothers and professionals;
- development and designing of community based support programs;
- the mixture of family support and health promotion;
- research for developing programs;
- cues necessary for innovative action;
- different perspectives for use by implementation of the programs.

The different roles of the mothers and professionals
In chapter 2 of this book Carolina Kleinjan on behalf of the visiting mothers of Kruiswerk Gezinszorg Breda explains the role of visiting mothers as volunteers in the Dutch program. An Irish or English mother might very easily have presented as inspiring and realistic a picture of the participant's view of the program. The mothers - the volunteers - are the core of a community based support program. This does not only apply to the actual carrying out of the program, but also to their involvement in the development of the program. After all if one wants to make a program based on "*the ideologies of empowerment, emancipation, and solidarity*", one cannot do without a decisive input on the part of the program's users. In a health care culture dominated by doctors and nurses this was not easy. It is vitally necessary to be seen to be credible and not just to pay lip service to the concept of empowerment. A program which has empowerment and solidarity of paramount at its core will, at the

very least, have to meet these standards. The ultimate consequence being that the mothers design their own programs. In this, we share Barker's stance in chapter five where he advocates not only community based, but also community led support programs with others in a facilitating and supportive role.

foto Willem Mes van MIM-programma toe te voegen

When we look at the programs in various countries, we see in the course of the development a shift in the professional attitude towards the role of the mothers. As innovation continues, the development moves forward and the recognition for the role of the mothers increases. In this respect, the changes in nurses, doctors and social workers are perhaps more important than the changes in the mothers themselves. In the mothers, there is 'merely' activation of potential resources and abilities. The attitudinal change in professionals is much deeper and more fundamental. We are of the opinion that a community based program requires professionals to adopt a modest and background role and allow the mothers to play the lead, preferably from the very beginning. The professionals should allow themselves thereby to be in the service of the mothers.

Development and designing

The role of the mothers and professionals is one aspect of the development of community based support programs which contributes to the potential success of this type of program. One question remains; what makes the designing of such programs potentially successful? As of yet, we can only speak of potential success, due to the lack of published studies on the programs effectiveness. There are favourable indications of effects on health and independence (Johnson, 1992; Maloney, 1995; Wolf, 1995; Clinton & Matthews-Taylor, 1997) but we still await an international comparative study.

However, even with this reservation the question remains: what makes the program practicable and successful? When we compare the programs, we are struck by a number of common characteristics. We mention five common characteristics in the program design; a holistic approach, peer group home visiting, social support and networking, sharing experimental and specialist knowledge and participation and emancipation of women.

A holistic approach.
All the programs described take a more or less holistic view of man and life. Health and education, working and living, economic and social life are linked and are not seen as isolated in the program. Parents and mothers are faced with the entire and undivided care and education of their child. The development of their child is taking place in all imaginable areas: social, intellectual, material, emotional, physical. Action on the part of parents does not take place in isolation either, but occurs in more or less poor conditions, either with or without support of family and friends, with or without a job, income or social benefits. The mothers in the program are not just women with merely a 'mother's role'. In addition they have their own lives and experiences as a partner, as employee or unemployed person, as volunteer, friend, consumer or in any other capacity. They are being addressed as persons, as human beings with or without faults.
The holistic character is also expressed in the contents of the program, as we shall see in the next paragraph. There is an integration of socio-scientific and medico-scientific thought, a mixture of family support and health promotion programs.

Peer group home visiting
A second active ingredient of the program design is the quality of the program with the mothers acting both in their capacities as givers and receivers of information. The method of peer group education is opted for in combination with home visits. Mothers, themselves part of the target group, are also the carriers and messengers of the program's contents, as can be seen from the examples in part two of this book. Brenda Molloy uses the term de-roling in this context i.e. no more working for people but rather working with people. In theory one could put forward the proposition that the more the program is carried out by the target group, the more its range and possibly its effectiveness will increase (Gepkens and Gunning-Schepers, 1994). This is supported by program evaluations in

different countries. The high regard for the role of the mothers is particularly striking, probably helped by the program taking place in a familiar surroundings for the mothers. It is apparent that these mothers are seen as reliable and credible. "*This is really useful*", you can hear the mothers saying themselves. What these mothers do can be described as:
- *bringing knowledge within reach and finding it understandable ;*
- *reflecting on experiences and placing them in a certain context;*
- *listening;*
- *being there, evoking proximity or intimacy;*
- *giving personal attention;*
- *helping other women to rediscover their self-esteem;*
- *helping other women to cope with problems, and sometimes solving them.*

Many of these qualities we find in other circumstances in family, friendship and relationships. But not everybody is in a position to avail of those. It is then marvellous to get help offerd from someone who is in similar circumstances as youself. The method of peer group education and home visits is not unique to community based support programs. It is used in programs combating social exclusion, local public health promotion and health policy (Tenhaeff, Prinsen, et. al., 1994) and it is also used in the context of European employment programs.

Social support and networking

Social support plays an important role. This is recognised by mothers and health workers alike. It is also recognised that health and educational problems have a social component, both on an individual as on a group level. Support and networking is advocated and used on both levels in various ways:

1 There are three ways to express support as Hermanns states in chapter four of this book: emotional, informational, instrumental.
2 Mothers are being supported in forming networks themselves, making and maintaining contacts, and getting out of the house.
3 The health care workers cannot support and supervise the program without appealing to their network in the community in which they work. They also need the support of other workers in creches, community work, child health care, or police in order to publicise, administer and carry out the program adequately.
4 They need their network also to recruit mothers for participating or working in the program.

Sharing experimental and specialist knowledge

The program places equal value on the knowledge that mothers have gained from their own experience with caring and parenting their children and on the specialist knowledge of the different professional disciplines involved. A possible explanation for the program's success with mothers lies in the balance of the appreciation of these sources of knowledge. In the program it is the experienced mother's task to get specialist knowledge across using her personal experiences. In a way she translates the information into ready made chunks which the inexperienced mother understand, can use and relate to in her life. In the eyes of the inexperienced mother she is seen as the expert, namely an expert of and with children of her own.

Personal experiences, both positive and negative, have hardly any educational effect at all if they are not placed in a broader context. One mother's experiences will be accepted by another if they are seen to be linked to generally accepted knowledge, for example on education and child care. They increase the problem solving ability by adding a new element to the experience.
The program provides the mothers with an opportunity to reflect on experiences and they explore alternative "approaches". Mothers state in this respect: "*I am learning to pause and think of what I'm doing and to think of what I want.*"

Participation and emancipation

The last but not least characteristic might be the active and decisive role that the inexperienced and experienced mothers themselves play in the program. Their activities lead to more participation, due to their advertising by word of mouth, and create a basis of trust for the program among the target groups. The ultimate result could be a feeling of "*it is a program of our own*". At the individual level such emancipation will result in the discovery of "*being able to do much more than I thought possible*". The result of this "empowerment" is people regaining control over their own lives. This discovery sometimes has the consequence that people will develop talents in other directions. They

look at other possibilities and perhaps look for other roles. Women will seek jobs, start (further) education or engage in other voluntary work for the community.
In this perspective we may speak of emancipation effects of the program. These programs thus contribute, unintentionally, to the strategy of education and training as investment in health, advocated by the World Bank (1993).

A family support and health mixture

Community based support programs could perhaps owe their enthusiastic reception by the target group to the synthesis, that is created between the worlds of health and welfare, the world of the individual and his immediate surroundings, and between laymen and professionals. In the previous paragraph we discussed this on the basis of the holistic approach. But this synthesis goes further than that.

Community based support programs are stimulated and initiated from two professional standpoints. The program is encouraged because it is seen as a possible means of addressing socio-economically determined health differences through health protection and promotion for people living in underprivileged circumstances. It is also seen as a towards the prevention of possible educational problems, the addressing of social issues in a neighbourhood and as an incentive to emancipatory development. The holistic approach in these programs has not only to do with the professional environment from which they are initiated, but also touches upon the programs' contents. Socio-scientific and health-scientific thought meet in these programs.
In the day-to-day reality of the mothers participating in the program, this provides a fruitful synthesis. We must understand that in the mothers' perception questions on education, care, health, growing, the child's development are side by side. These mothers do not make the same distinctions which empirical-analytical thought of science advocates. Rather, they link these separated worlds and ask for support "so that they can solve their own problems in their own way".

In other respect also, there has been a synthesis: the principles of family support programs are being combined with the principles of health promotion. In an analytical sense Bronfenbrenner, Super and Harkness laid the foundation for such an intervention program in the model of 'linked ecologies for child development', which Hanrahan described in chapter one of this book (Bronfenbrenner, 1979; Super and Harkness, 1986). Further theoretical in-depth treatment of the intervention model of community based support programs can be linked to this model. It opposes intervention programs based on a strictly medical-preventative model with its highly prescribing nature. The current programs are linked in with a combination of social embedding, social support and individual development as principles of change. As was stated before, it would be an exiting prospect using a similar conceptual framework in developing a theoretical model of community based support programs for children in need and their parents.

Research for developing programs

Evaluating community based support programs is difficult and many colleagues are struggling to find a research approach to fit the program. Koelen & Hanrahan in their chapter give some building blocks for developing an adequate research method. Four issues seems to be involved:

1. The development of a program requires a development-oriented approach on the part of the research itself. Action research seems to be indicated. Initially the results of such research cannot reach beyond the feasibility of the program and identification of the active ingredients (Barker and Anderson, 1988; Wolf, 1995).
2. A process evaluation can be carried out quite easily, but it will not clarify the program's achievements, only its feasibility. This type of evaluation will facilitate go, no go decisions in the development phase of the program and at the beginning of the implementation phase. In addition, it provides an insight into the course, mode of operation and interaction of the program itself. It can be a pitfall to use such research as a standard to measure the effects of the program on the child or its mother.
3. A program in development can be evaluated, but a stage has not yet been reached where

demonstrated effects can be produced. Standardisation is first required. Only then does research into community interventions appear with the same authority as that produced by randomised control trials (Sturmans, Nutbeam et. al., 1997).

4 If there is to be implementation at all levels, national and institutional policy and program execution, we will then be faced with the predictable question as to the proved effectiveness of a program. This means that great care must be taken in the correct timing of any proposed research, if the program is to develop properly. Standardisation is, however, only possible when action research and process evaluation have provided sufficient insight into the effectiveness and feasibility of the program. The discussion on the effectiveness of the HIPPY program in Israel and the Netherlands is one example of the "burden of proof" question which will arise when programs are being implemented on a national scale.

It is comforting to know that if effectiveness is demonstrated by means of 'stricter research standards, the possibilities for implementation increase. Ireland has a head start in this regard due to research by Johnson (et al, 1993).

Cues for action needed for innovations

New programs and therefore community based support programs also, need a 'cue for action' to provoke individual professionals to change. Analogous to the 'health belief model' to bring about an attitudinal and behavioural shift among doctors, nurses, information officials and policy makers, an actual and real cue is needed to initiate change. Innovation does not take place spontaneously. Professionals do not change, as "*the manager says it is necessary*". They need a personal motive to believe in something as new as community based support programs. Such programs will gain a stronger innovation potential if they engenders an deep-rooted motivation. In the programs discussed in this book this 'cue for action' for professionals can be situated in:
- empowerment: professionals discover and gain trust in people's own powers and abilities;
- professional impotence: the repeated experience of not being able to reach people, in particular in underprivileged circumstances, with prescribing behaviour as opposed to the introduction to the results of an activating attitude and behaviour;
- the communication gap: the inability on the part of professionals to transfer knowledge, information and skills to the public (the mothers);
- solidarity: the manifest need to provide support and care to the weakest members of society;
- program effects: the pedagogical, health and socio-economic effects of 'community based support programs';
- vision on man and science: lifting the separation of the sciences; breaching the gap between the medico-scientific and the socio-scientific thinking and the effects of this separation for mothers and children.

Professionals can therefore derive their personal motivation for co-operation in the program from various elements. And yet the program hardly gets away from the level of the individual professional, who "*believes in the role of community mothers*". More is required to progress from programs based on 'the beliefs of individuals' to locally, nationally and internationally established programs.

"*Think global, act local*" is an often heard expression in circles of the WHO and other international health organisations (Evers et.al., 1990). It expresses very well the two simultaneous and interacting, yet very different strategies which are necessary in order to improve people's health and quality of life on a wider scale. Van Oudenhoven and Wazir dealt with this extensively in chapter 11 on strategies for the increasing coverage of programs for children.

What else is needed, in addition to proof of effectiveness and sufficient motives for professionals, in order to improve the dissemination and quality of programs to such an extent that general acceptance is coming within reach? The experiences in Nashville, the different locations in Ireland, Wales and the Netherlands all teach us everything must be done at three levels: a local focal point, the community at large, and nationally. Let us examine the different levels at which improvements in dissemination of information and the quality of life can be implemented: the decisive link of the mothers' world and the professionals.

1 The participating community needs a focal point. The empowering attitude and the pro-activating behaviour of nurses and doctors are according to Barker and others decisive for a chance of success. In the local community the program is being given a human face, resulting in the mothers feeling that the program is theirs.

2 On a community level we find the specified applications of the programs each with their specific program conditions and management. The organisation is locally embedded in the community and within this representatives of the target groups are given a voice. Local nurses or social workers take care of the continuous assessment of the program to ensure quality of care. On this level continuous adjustment is necessary all the time. Re-inventing the wheel is not necessary, for it is quite possible conceptually to transfer, implement and disseminate community based support programs but utilisation and adaptation according to local needs and circumstances will always be necessary.

3 On the national level program-concepts can be compared, ideology and paradigms can be analyzed, and implementation strategies utilised. The national program strategy can help to ensure continuity of funding.

Perspectives of implementation

The availability of a potentially successful program is not enough to implement a community based support program on a larger scale. This will take much more. Young parents should be made aware of the possibilities of participating in the program when and if needed. Individual health care workers need to foster a public-oriented attitude and the management structures of community nursing services or welfare organisations need to examine the advantages of the program in terms of the number of parents from the different target groups reached, spin-off effects in relation of positive public image towards their organisation and unit costs.
Local circumstances are seldom ideal for an undisturbed start of the program. Funding is often subject to freakish patterns. Sandison and Sheridan describe in their chapters that this is an ongoing worry unless one is able to create a solid foundation within the organisation or in politics. Community based support programs are not spectacular headline grabbing programs giving quick results and it can often take ten years before substantial effects are shown (Olds et al, 1993).

It will thus continue to take a considerable effort on the part of the mothers and professionals to place these programs on the political agenda of policy makers and practitioners. A more general restriction is that these programs are suffering from the limited insight into the costs of prevention. There is an enormous need for evaluative research and proof of effectiveness on health determinants, costs, education attainment and other social variables as a result of these programs. These restrictions however, need not be an obstacle to an efficient dissemination of innovative community based support programs. Chances for implementation increase as more successful activities within the programs are identified and some hard evidence is published.

In conclusion

Implementing community based support programs is possible, but will have to be nurtured in coming years with special attention given to:

- quality improvement of program development in strengthening the synthesis of family support programs and health promotion;
- stimulating participation of the target groups;
- marketing strategies which are well constructed and adequately managed and focused on policy makers, health care workers and the general public;
- evaluating research of cost effective programs.

We put forward the suggestion that a joint plan of action be drawn up with a view to realising the goals of wider dissemination of this type of program. A similar co-operation existed in the past between the University of Bristol, the Dutch Kruiswerk Gezinszorg Breda and the Eastern Health Board in Dublin and nowadays between the Netherlands Institute of Care and Welfare, the MIM Cooperative and the Birmingham Health Authority with a view to an international exchange of experiences. This joint plan of action could also include a first step towards developing a research

proposal for an international evaluation study. The participants at the conference discussed the possibility of setting up a newsletter with a view to information exchange. Finally, a biennial (inter)national "*Community Mothers Day*" was suggested, which could be coupled with an international conference where mothers, health care workers and others could meet to exchange their experiences and learn from each others different expertise. The suggested Community Mothers Day could be an ideal platform for everyone to see and acknowledge that the participating mothers are all and everything in these programs.

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